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agency a copy of its most current accreditation survey, together with any information related to the survey that CMS may require (including corrective action plans).

(2) CMS may determine that a provider or supplier does not meet the Medicare conditions on the basis of its own investigation of the accreditation survey or any other information related to the survey.

(3) Upon written request, CMS may disclose the survey and information related to the survey—

(i) Of any HHA; or

(ii) Of any other provider or supplier specified at paragraph (a) of this section if the accreditation survey and related survey information relate to an enforcement action taken by CMS.

[58 FR 61840, Nov. 23, 1993, as amended at 62 FR 46037, Aug. 29, 1997; 64 FR 67052, Nov. 30, 1999; 72 FR 15278, Mar. 30, 2007]

§ 488.7 Validation survey.

(a) *Basis for survey.* CMS may require a survey of an accredited provider or supplier to validate its organization's accreditation process. These surveys will be conducted on a representative sample basis, or in response to substantial allegations of noncompliance.

(1) When conducted on a representative sample basis, the survey is comprehensive and addresses all Medicare conditions or is focused on a specific condition or conditions.

(2) When conducted in response to a substantial allegation, the State survey agency surveys for any condition that CMS determines is related to the allegations.

(3) If the State survey agency substantiates a deficiency and CMS determines that the provider or supplier is out of compliance with any Medicare condition, the State survey agency conducts a full Medicare survey.

(b) *Effect of selection for survey.* A provider or supplier selected for a validation survey must—

(1) Authorize the validation survey to take place; and

(2) Authorize the State survey agency to monitor the correction of any deficiencies found through the validation survey.

(c) *Refusal to cooperate with survey.* If a provider or supplier selected for a validation survey fails to comply with the requirements specified in paragraph (b) of this section, it will no longer be deemed to meet the Medicare conditions but will be subject to full review by the State survey agency in accordance with § 488.11 and may be subject to termination of its provider agreement under § 489.53 of this chapter.

(d) *Consequences of finding of noncompliance.* If a validation survey results in a finding that the provider or supplier is out of compliance with one or more Medicare conditions, the provider or supplier will no longer be deemed to meet any Medicare conditions. Specifically, the provider or supplier will be subject to the participation and enforcement requirements applied to all providers or suppliers that are found out of compliance following a State agency survey under § 488.24 and to full review by a State agency survey in accordance with § 488.11 and may be subject to termination of the provider agreement under § 439.53 of this chapter and any other applicable intermediate sanctions and remedies.

(e) *Reinstating effect of accreditation.* An accredited provider or supplier will again be deemed to meet the Medicare conditions in accordance with this section if—

(1) It withdraws any prior refusal to authorize its accreditation organization to release a copy of the provider's or supplier's current accreditation survey;

(2) It withdraws any prior refusal to allow a validation survey; and

(3) CMS finds that the provider or supplier meets all the applicable Medicare conditions. If CMS finds that an accredited facility meets the Life Safety Code Standard by virtue of a plan of correction, the State survey agency will continue to monitor the facility until it is in compliance with the Life Safety Code Standard.

[58 FR 61840, Nov. 23, 1993]

§ 488.8 Federal review of accreditation organizations.

(a) *Review and approval of national accreditation organization.* CMS's review and evaluation of a national accreditation organization will be conducted in